MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

00993

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke city, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Pocomoke city, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME George William Adams

3. (b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife ✓
6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) March 22, 1871

8. AGE: Years	Months	Days	If less than one day
73	10	6	hrs. min.

9. Birthplace Rehoboth, Somerset, Md.
(Town, county, and state)
10. Usual occupation Waterman
11. Industry or business
FATHER 12. Name George L. Adams
13. Birthplace Maryland
MOTHER 14. Maiden name Sally Adams
15. Birthplace Maryland
16. Informant Mrs. Gordon Purnell
Address Pocomoke city, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30, 1945 (month) (day) (year)
Cemetery or crematory Salem M. E.
Location Pocomoke city, Md.
18. Funeral director Marguette H. Watson
Address Pocomoke city, Md.
19. Jan. 30 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28th 1945 at 8 A.M. (45)
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1945, to Jan 27 1945
and that I last saw h alive on Jan 27th 1945
Immediate cause of death Cyanosis, Disease Gangrene — DURATION: month
Due to
Due to
Other conditions Myocarditis — DK
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State) Md.
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. E. Adams M. D. or other
Address Pocomoke City Md Date signed 1/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (a)

CERTIFICATE OF DEATH

00994

Reg. Diat. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 217 Walnut Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rebecca Elizabeth Ashburn

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife: Quince Ashburn

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): April 14, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	14	...hrs. ...min.

9. Birthplace: Asbury Park-Monmouth-New Jersey (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: William H. Downing

FATHER — 13. Birthplace: Philadelphia, Penna.

MOTHER — 14. Maiden name: Ada Kiem

MOTHER — 15. Birthplace: Philadelphia, Penna.

18. Informant: Quince Ashburn

Address: 217 Walnut St., Pocomoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 30, 1945 (month) (day) (year)

Cemetery or crematory: Presbyterian Cemetery

Location: Pocomoke City, Maryland.

18. Funeral director: H. Harvey Bradshaw

Address: Pocomoke City, Maryland.

19. Jan. 30, 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 1945 at 8:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to Jan 28 1945 and that I last saw h... alive on Jan 27 1945

Immediate cause of death	DURATION
Acute Myocarditis	2 days
Due to Embolism of Pulmonal Artery	10 days
Due to Chronic Valvular Heart Disease	years
Other conditions Diabetes	years

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. E. Litchfield M. D. or other

Address: Date signed: 1-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 22

00995

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH:

County: Worcester

City or town: RURAL, Stockton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: RURAL, Stockton (If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD # 2 Box 110 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Edward J. Bonneville

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Elizabeth Manuel Bonneville

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): December 16, 1857

8. AGE: Years	Months	Days	If less than one day
87	0	15	... hrs. ... min.

9. Birthplace: Worcester County-Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Truck farming

FATHER

12. Name: Jacob Bonneville

13. Birthplace: Worcester County, Maryland

MOTHER

14. Maiden name: Betsy Taylor

15. Birthplace: Worcester County, Maryland

16. Informant: John H. Bonneville

Address: Stockton, Md. # RFD 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3 1945 (month) (day) (year)

Cemetery or crematory: Old St. Pauls Cemetery

Location: Stockton, Md. RFD # 2

18. Funeral director: Irving Bennett

Address: Stockton, Maryland

19. Jan 2 1945 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1st 1945, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26th 1944, to Dec 27 1944

and that I last saw h[illegible] alive on ... 1944

	Duration
Immediate cause of death	
Due to: Bulbar Paralysis	Two days
Due to: Arteriosclerosis	Seven yrs
Other conditions: [illegible] (bronchial) (Include pregnancy within 3 months of death)	Two yrs

Major findings of operations ... Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: N. E. Sartorius M.D. (M. D. or other)

Address: Pocomoke City Md. Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

CERTIFICATE OF DEATH

00996

Reg. Diat. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Worcester
City or town Near ~~Berlin~~ Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin Ocean City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Jerry Ruley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col'd	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years 69 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace unknown (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden name unknown

15. Birthplace

16. Informant Joseph Savage

Address Ocean City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/9/45 (month) (day) (year)

Cemetery or crematory St. Pauls (colored)

Location Berlin, Md.

18. Funeral director Franklin P. Hill

Address Salisbury Md.

19. 1-9- 1945 Robert T. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 19 45, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Apoplexy	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John L. Riley Dep. Med Exam
M. D. or other
Address Snow Hill Md Date signed 1/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

00997

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:

County Worcester

City or town Snow Hill R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County

City or town Philadelphia

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Harry Carson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh	married.

6.(b) Name of husband or wife Tessora Carson.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1903

8. AGE:

Years	Months	Days	If less than one day
41	2	11	..... hrs. ..... min.

9. Birthplace New Jersey

(Town, county, and state)

10. Usual occupation Truck Driver.

11. Industry or business

FATHER

12. Name Pearson Carson

13. Birthplace N. J.

MOTHER

14. Maiden name Unknown

15. Birthplace

16. Informant David B Frankenfield & Sons

Address 317 N. 52nd St. Phila. Pa.

17. Burial Date thereof 1/30/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Yardley Cem.

Location Yardley N. J.

18. Funeral director Franklin B. Hall.

Address Salisbury Md.

19. 1/27 1945 LeRoy Smith.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 26 1945 at 1 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Burned to death in a truck	
Due to Collision	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 1/26/45

Where did injury occur? Near Snow Hill Worcester Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Highway

Means of injury Burned in a truck Injured at work? yes

23. SIGNATURE John L. Reay Dep Med Exam

M. D. or other

Address Snow Hill Md Date signed 1/26/45

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

00998

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ralph Cropper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1885

8. AGE: Years 59 | Months | Days | If less than one day hrs. min.

9. Birthplace Bishopville, Worcester Co. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER
12. Name Charles W. Cropper
13. Birthplace Bishopville, Md.

MOTHER
14. Maiden name Annie E. Gray
15. Birthplace Bishopville, Md.

16. Informant Mr. Horace Cropper
Address Berlin, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/1/45 (month) (day) (year)
Cemetery or crematory Odd Fellows Cem.
Location Bishopville, Md.

18. Funeral director Franklin B. Lail.
Address Salisbury Md

19. 2-1-45 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH about Jan 28 1945, at (?) M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Myocardial degeneration	Unknown
Heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John L. Riley Dep. Med Examr
M. D. or other
Address Snow Hill Md Date signed 1/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (86)

00999

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester Co.
City or town Pocomoke City Md Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke, Md. - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Susie Bessie Cropper

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C.	S.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1944

8. AGE: Years 9 | Months 5 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace near Pocomoke City Md Rural
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name Oscar Cropper
13. Birthplace St Jones Worcester Co Md

MOTHER
14. Maiden name Rowena Jones
15. Birthplace Worcester Co Md

16. Informant Rowena Cropper
Address Pocomoke City Md RFD #2

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 1/27/45 (month) (day) (year)
Cemetery or crematory St James Cemetery
Location Worcester Co. Md

18. Funeral director Oscar Funeral director
Address Pocomoke City Md RFD

19. Jan 27 1945 Arnold E. White Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-26-1945 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Unconscious 19 ... to ... 19 ... and that I last saw h alive on 1-26- 19 45

Immediate cause of death	DURATION
Convulsions (Uraemic)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. E. Anderson Deputy Md Exam. M. D. or other
Address Pocomoke City Md Date signed 1/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

01000

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 72 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newboro infants give residence of mother)

State Maryland County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Horace Davis.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Jennie Bowen Davis.

6.(c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) October 18, 1872

8. AGE:

Years	Months	Days	If less than one day
72	3	10	hrs. min.

9. Birthplace Berlin, Worcester Co. Md.
(Town, county, and state)

10. Usual occupation Lace Manufacturer.

11. Industry or business

FATHER

12. Name Henry Davis.

13. Birthplace Berlin Md

MOTHER

14. Maiden name Maria Elizabeth Davis

15. Birthplace Berlin, Md.

16. Informant Mrs. Horace Tenille

Address Berlin, Md.

17. Burial Date thereof 1/30/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Buckingham Cem

Location Berlin Md

18. Funeral director Franklin B. Hall

Address Salisbury, Md

19. 1-30 1945 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 19 45 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 38, to Jan 28 19 45

and that I last saw him alive on Jan 28 19 45

Immediate cause of death	DURATION
Mitral Insufficiency + Stenosis	5 yrs
Due to Myocardial Hypertrophy & Dilitation	40 yrs
Due to Hypertensive Heart Disease	40 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederick L. Incoll M.D.
M. D. or other

Address Berlin, Md Date signed 1/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

01001

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke city, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. Second
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Grayson DeWitt Ditto

3.(b) Social Security Number 213-01-7220

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife ✓
6.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) June 9, 1906

8. AGE:

Years	Months	Days	If less than one day
38	5	20	hrs. min.

9. Birthplace Jackson Barracks, La (Town, county, and state)
10. Usual occupation Helper in store
11. Industry or business

FATHER
12. Name Rev. John A. Ditto
13. Birthplace West Virginia

MOTHER
14. Maiden name Katherine Shirk
15. Birthplace Maryland

16. Informant Rev. John A. Ditto
Address Pocomoke city, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31, 1945 (month) (day) (year)
Cemetery or crematory Hall's Hill
Location Pocomoke city
18. Funeral director Margarette H. Watson
Address Pocomoke city, Md.

19. Jan. 31 1945 (Date rec'd by registrar) Asa E. Whelan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29th 1945, at 5:30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 28 1945, to Jan 29th 1945
and that I last saw h... alive on Jan 29th 1945

Immediate cause of death	DURATION
Apoplexy	14 hours
Cerebral Hemorrhage	
Due to Hypertension	2 years +
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. E. Carlton M.D.
M. D. or other
Address Pocomoke City Md. Date signed 1/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01002

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH:

County: Worcester

City or town: Newark RFD
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Yrs

Hospital, Institution, or street address where death occurred: X

How long in hospital or institution? X

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Newark, Md. RFD
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) X

2.(a) If veteran, name war

3.(a) FULL NAME: CHARLOTT ELIZABETH DOWNS

3.(b) Social Security Number: X XXX

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Joseph Downs

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Jan. 9, 1886

8. AGE: Years: 59 | Months: 0 | Days: 22 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housework

FATHER
12. Name: James Butler
13. Birthplace: Md.

MOTHER
14. Maiden name: Charlott Elizabeth Holland
15. Birthplace: Md.

16. Informant: Mr. Joseph Downs
Address: Newark, Md. RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 3, 1945 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin, Md.

18. Funeral director: M. Pasha Watson

Address: Selbyville, Del.

19. 2/3 1945 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31 1945, at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1940, to Jan 31 1945 and that I last saw her alive on January 31 1945

	DURATION
Immediate cause of death: Diabetis Mellitis	4 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. S. Purnell, M. D. (M. D. or other)

Address: Berlin, Md. Date signed 2/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and ~~legibly~~

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

01063

Reg. Diat. No. 351

1. PLACE OF DEATH:
County: Worcester.
City or town: Snow Hill R F D-
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester.
City or town: Berlin.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Fulton Ewell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ella B. Ewell.
6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): July 30, 1919

8. AGE: Years	Months	Days	If less than one day
25	5	26	hrs. min.

9. Birthplace: Berlin, Worcester Co. Md.
(Town, county, and state)
10. Usual occupation: Truck Driver.
11. Industry or business

FATHER
12. Name: Calvin Ewell.
13. Birthplace: Berlin Md.

MOTHER
14. Maiden name: Agnes Tilden.
15. Birthplace: Ironshire Md.

16. Informant: Mrs. Calvin Ewell
Address: Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Data thereof 1/28/44 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin Md.

16. Funeral director: Franklin B. Reid.
Address: Salisbury Md

19. 1/27/ 19 45. (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 19 45 at 1 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~ 19 to ~ 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Burns to death in a truck	
Due to: Collision	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of Jan 26 45
Where did injury occur? Near Snow Hill Worcester Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public highway
Means of injury: Burned in truck Injured at work? Yes

23. SIGNATURE: John L. Riley D to Med Exam
M. D. or other
Address: Snow Hill Md Date signed: Jan 26 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01004

Reg. Dist. No. 955

1. PLACE OF DEATH:
County: Worcester
City or town: (If outside city or town limits, write RURAL and give nearest town) Whaleysville Md Rural
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: (If outside city or town limits, write RURAL and give nearest town) Whaleysville Rural
Street No.: (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Levin Thomas Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Lovana Parker Jones
6.(c) If alive, give age: 75 years
7. Birth date of deceased (mo., day, yr.): - 1881

8. AGE: Years: 64 | Months: - | Days: - | If less than one day: hrs. min.

9. Birthplace: Whaleysville, Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business:
FATHER 12. Name: Levin Jones
FATHER 13. Birthplace: Delaware
MOTHER 14. Maiden name: Clarissa Hall
MOTHER 15. Birthplace: Md.
16. Informant: Lovana Parker Jones
Address: Whaleysville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 31 1945 (month) (day) (year)
Cemetery or crematory: Whaleysville Cem.
Location: Whaleysville, Md.
18. Funeral director: Marguerite S. Watson
Address: Pocomoke City, Md.
19. 1-31-45 (Date rec'd by registrar) Helen E. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 1945, at 6:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1945 19.. to day of death 19..
and that I last saw him alive on day of death 19..

Immediate cause of death	DURATION
Carcinoma of liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank G. Lewis M.D.
Address: Willards Md. M. D. or other
Date signed 1-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01005

Reg. Dist. No. 955

1. PLACE OF DEATH:
County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Garley Lewis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown.

8. AGE: Years: About 60 yrs. Months: Days: If less than one day: hrs. min.

9. Birthplace: Whaleyville Md.
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business:

FATHER
12. Name: James Lewis
13. Birthplace: Md.

MOTHER
14. Maiden name: Ellen Davis
15. Birthplace: Md.

16. Informant: John Lewis
Address: Whaleyville. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20, 1945 (month) (day) (year)
Cemetery or crematory: Lewis Cemetery.
Location: Whaleyville. Md.

18. Funeral director: M. Pasha Watson
Address: Selbyville, Del.

19. 1-20 (Date rec'd by registrar) 1945 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18, 1945 19... at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-18-1945 19... to 1-18-1945 19...
and that I last saw him alive on 1-18-45 19...

Immediate cause of death	DURATION
angina pectoris	1 hour
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R Lewis M.D.
M. D. or other
Address: Millsboro Del. Date signed 1-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

01006

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester.
City or town Berlin.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester.
City or town Berlin.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME J. Bert McCabe.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower.

6.(b) Name of husband or wife Mazelle McCabe.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1860

8. AGE: Years	Months	Days	If less than one day
84	1	4	..... hrs. ..... min.

9. Birthplace Roxana Delaware. (Town, county, and state)
10. Usual occupation Retired farmer.
11. Industry or business
FATHER 12. Name Jonathan McCabe.
13. Birthplace Roxana Del.
MOTHER 14. Maiden name Elizabeth Melvin.
15. Birthplace Roxana Delaware.
16. Informant Mrs. Calvin Wimbrough.
Address Berlin Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10/45 (month) (day) (year)
Cemetery or crematory Roxana Cemetery.
Location Roxana. Delaware
18. Funeral director Franklin B. Idell.
Address Salisbury Md
19. 1-10 (Date rec'd by registrar) 1945 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8th 1945 at 6:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1942 19..., to Jan 8 1945
and that I last saw him alive on Jan 7 1945

Immediate cause of death	DURATION
Chronic Myocarditis	10 yrs
Due to Generalized Arteriosclerosis	20 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Purcell, M.D. M. D. or other
Address Berlin Md Date signed 1-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01067

(70-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: near Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? /
Hospital, institution, or street address where death occurred: /
How long in hospital or institution? / dead

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Bay St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John E. Morris

3. (b) Social Security Number: Condom Destroyed in fire unused

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Wh.	Married

6.(b) Name of husband or wife: Cathleen Morris
6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): Oct. 5, 1923

8. AGE: Years: 21 | Months: 3 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Whaleyville, Md.
(Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business: "

FATHER
12. Name: John F. Morris
13. Birthplace: Whaleyville, Md.

MOTHER
14. Maiden name: Daisy Powell
15. Birthplace: Whaleyville, Md.

16. Informant: John F. Morris
Address: Whaleyville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 28 1945 (month) (day) (year)
Cemetery or crematory: Whaleyville Cemetery
Location: Whaleyville, Md.

18. Funeral director: M. Pasha Watson
Address: Selbyville, Del.

19. 1/27 1945 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1945, at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.., to — 19..
and that I last saw h... alive on — 19..

Immediate cause of death	DURATION
Burns to death in a truck	—
Due to: Collision	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.: .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Jan 26 '45
Where did injury occur? near Snow Hill (City or town) Worcester (County) Md. (State)
Injured at home, farm, industry, public place (where?): Public Highway
Means of injury: Burns in truck Injured at work? Yes

23. SIGNATURE: Glen L. Riley Dep. Med Exam M. D. or other
Address: Snow Hill Md. Date signed: 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89a

01068

CERTIFICATE OF DEATH

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Worcester.

City or town Newark Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester.

City or town Newark, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles W Mumford

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Mamie C Mumford.

6(c) If alive, give age 64. years

7. Birth date of deceased (mo., day, yr.) June 25 1870

8. AGE: Years	Months	Days	If less than one day
74	6	18	hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Thomas Mumford

13. Birthplace Md.

MOTHER 14. Maiden name Catherine Nichols

15. Birthplace Md.

16. Informant Hirons Mumford

Address Frankford Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15 1945 (month) (day) (year)

Cemetery or crematory Bowers M. E.

Location Newark Md

18. Funeral director Clinton K. Watson

Address Frankford Delaware

19. 1/18 (Date rec'd by registrar) 19 45 LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 18. 1945, at 9A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1945, to Jan 13 1945

and that I last saw h / m alive on Jan 13 1945.

	DURATION
Immediate cause of death Cerebral apoplexy	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford E Schott M.D.
M.D. or other

Address Berlin Md. Date signed 1/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

01089

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pa. County .....
City or town Philadelphia
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME James R. Nelson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married.

6.(b) Name of husband or wife Gladys Nelson
6.(c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) July 6 1906

8. AGE:	Years	Months	Days	If less than one day
	38	6	20	..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business
FATHER 12. Name George Nelson
13. Birthplace Va.
MOTHER 14. Maiden name Betty Jane Williams
15. Birthplace Md.
16. Informant Mr. Lloyd Harriet
Address 5816 Vine St. Phila. Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/45 (month) (day) (year)
Cemetery or crematory .....
Location Philadelphia Pa
18. Funeral director Franklin B. Hill.
Address Berlin Md.
19. 1/27 1945 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26 1945 at 1 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Burns due to a truck fire	—
Due to Collision	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 1/26/45
Where did injury occur? Near Snow Hill Worcester Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Highway
Means of injury Burns in truck Injured at work? Yes

23. SIGNATURE John L. Riley Dep. Med. Exam.
M. D. or other
Address Snow Hill Md. Date signed 1/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01010

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke city, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore city
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Groner C. Nottingham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lela Nottingham
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 27, 1891

8. AGE:

Years	Months	Days	If less than one day
53	11	27	hrs. min.

9. Birthplace Eastville, Northampton, Va
(Town, county, and state)
10. Usual occupation Farming
11. Industry or business

FATHER
12. Name William T. Nottingham
13. Birthplace Virginia

MOTHER
14. Maiden name Ella Wyatt
15. Birthplace Virginia

16. Informant Mrs. Fletcher Miles
Address Pocomoke city, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 26, 1945 (month) (day) (year)
Cemetery or crematory Salem M. E.
Location Pocomoke city

18. Funeral director Marguette & Sturgeon
Address Pocomoke city, Md.

19. Jan 25 1945 Addie E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 24 1945, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 22 1945 to Jan 24 1945 and that I last saw h alive on Jan 23 1945

Immediate cause of death Lobar Pneumonia — DURATION 4 Days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. [illegible] M. D. or other
Address Date signed 1-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-2)

CERTIFICATE OF DEATH

01011

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Rural - Berlin Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: WORCESTER
City or town: BERLIN R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Purnell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 2, 1866

8. AGE: Years	Months	Days	If less than one day
79	9	14	hrs. min.

9. Birthplace: Berlin Worcester, Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Jacob Robbins
13. Birthplace: Berlin, Md.

MOTHER
14. Maiden name: Zean Purnell
15. Birthplace: Berlin, Md

16. Informant: Wilmer Purnell
Address: BERLIN, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/45 (month) (day) (year)
Cemetery or crematory: St. Pauls Cemetery
Location: BERLIN, MD.

16. Funeral director: Franklin F. Dill.
Address: Salisbury, Md

19. 1-20- 19 45 (Date rec'd by registrar) Helen A. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY 16 19 45 at 10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 10 19 45 to Jan 16 19 45 and that I last saw h... alive on Jan 14 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to Chronic Nut Nephr.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford E. Jacobs M. D. or other
Address: Berlin Md Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

01012

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester
City or town Near Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? ma

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Brodell Town
(If outside city or town limits, write RURAL and give nearest town)
Street No. no R.F.D.
(If rural, give LOCATION) no
2.(a) If veteran, name war

3.(a) FULL NAME Mary M. Quillen

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col'd	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15 about 1893

8. AGE: Years 51 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Berlin Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business —

FATHER
12. Name Irving Quillen
13. Birthplace Berlin Md

MOTHER
14. Maiden name Rachael Warren
15. Birthplace Berlin Md

16. Informant Charlie Hudson
Address Berlin, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11 1945 (month) (day) (year)
Cemetery or crematory Evergreen
Location Berlin Md
18. Funeral director James T. Stewart
Address Salisbury Md

19. 1-11-1945 (Date rec'd by registrar) Helen E. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1945, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.. to — 19..
and that I last saw h... alive on — 19..

	DURATION
Immediate cause of death: Apoplexy	a few minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE John L. Riley Dep. Md Exam M. D. or other
Address Snow Hill Md Date signed 1/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01013

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Bessie Rodbell

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Abraham Rodbell
6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 73 | Months: — | Days: — | If less than one day: hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Joseph Stuck
13. Birthplace: Poland

MOTHER
14. Maiden name: unknown
15. Birthplace: "

16. Informant: Sonia J. Rodbell
Address: Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 14 1945 (month) (day) (year)
Cemetery or crematory: —
Location: Philadelphia Pa

18. Funeral director: Margaretta E. Watson
Address: Pocomoke City Md

19. Jan 13 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

A. M.

20. DATE OF DEATH: January 13th, 1945 at 11:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10th 1945, to 1/13th 1945 and that I last saw h.e.r alive on January 13th, 1945

Immediate cause of death	DURATION
Exhaustion	3 Days
Due to: Cerebral hemorrhage,	3 Days.
Due to: Hypertension- arterio sclerosis and Myocarditis.	Years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.: —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R Lee Bace M. D. or other
Address: Pocomoke City Md Date signed: 1/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01014

CERTIFICATE OF DEATH

Reg. Diat. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: 713 Short Street

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snowhill
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dixie Alley
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Calvin Savage

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Clara Northan Savage

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Do not Know.

8. AGE: Years	Months	Days	If less than one day
About 70			..... hrs. ..... min.

9. Birthplace: Mappsville, Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Edmond Savage
13. Birthplace: Accomack County, Va

MOTHER
14. Maiden name: Mary Harmon
15. Birthplace: Accomack County, Va

16. Informant: Beatrice Long

Address: 713 Short St., Pocomoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: January 14, 1945 (month) (day) (year)

Cemetery or crematory: Atlantic M. E.

Location: Atlantic Virginia

18. Funeral director: J. Edgar Thomas

Address: Accomac, Virginia

19. Jan. 14, 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10, 1945, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 9, 1945, to Jan. 10, 1945 and that I last saw h... alive on Jan. 9, 1945

Immediate cause of death: Lobar Pneumonia — DURATION: 1 wk.

Due to: —

Due to: —

Other conditions: Alcoholism

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert Le La Mar, M.D.
M. D. or other

Address: Snowhill Date signed: Jan. 12, '45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

01015

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Myrtle G. Scott

3. (b) Social Security Number 214-12-5394

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife Frank Scott

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 29, 1880

8. AGE:

Years	Months	Days	If less than one day
64	7	28	..... hrs. ..... min.

9. Birthplace Eckhart, Allegheny, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Joseph B. Garrett
13. Birthplace Virginia

MOTHER
14. Maiden name Nancy E. Anderson
15. Birthplace Eckhart, Md.

16. Informant Mrs. Robert Scott
Address Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30, 1945 (month) (day) (year)
Cemetery or crematory Salem M. E.
Location Pocomoke city, Md.

18. Funeral director Margarette H. Watson
Address Pocomoke city, Md.

19. Jan. 30 1945 (Date rec'd by registrar) And E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27th, 1945, at 5:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10th, 1945, to 1/27/45, 19.....
and that I last saw her alive on January 15th, 1945

Immediate cause of death	Collapse of heart	DURATION: Suddenly.
Due to	Chronic myocarditis,	Years
Due to	Hypertention.,	Years
Other conditions	Not any known.	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results Not any.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE R. Lee Hall M. D. or other
Address Pocomoke City, Md Date signed 11/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01016

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Newark Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Sallie Whaley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Charles Whaley
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 5 1875

8. AGE: Years: 70 | Months: 0 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Newark Worcester Md
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: George W. Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Pinkentown
15. Birthplace: "

16. Informant: Mr. Ridgway Whaley
Address: Ridgely, Md Rural #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 19 45 (month) (day) (year)
Cemetery or crematory: Cedar Chapel
Location: Newark, Md

18. Funeral director: Deane & Dennis
Address: Snow Hill, Md

19. 1/18 19 45 LeRoy Smith Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 19 45, at 11 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-14 19 45 to 1-15 19 45 and that I last saw h... alive on 1-14 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. E. Ickett M. D.
M. D. or other
Address: Newark Md Date signed: 1-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01017

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 Years
Hospital, Institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME William H. White

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Delsie White
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): December 12 - 1877

8. AGE:

Years	Months	Days	If less than one day
77	1	18	...hrs. ...min.

9. Birthplace: Rural Pocomoke Worcester Md.
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: ✓

FATHER
12. Name: George White
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: ✓

16. Informant: Edward "P" White
Address: Fort Myer Virginia

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) Feb (day) 7 (year) 1945
Cemetery or crematory: St. James Cemetery
Location: Rural Pocomoke Md.

16. Funeral director: Margaritta D. Watson
Address: Pocomoke City Md.

19. Feb. 2 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1944 to Jan 30 1945
and that I last saw him alive on Jan 30 1945

Immediate cause of death	DURATION
Myocardial degeneration	2 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: ... M. D. or other
Address: ... Date signed Feb 2 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-6

01018

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4th St
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Franklin Pierce Wilkerson Sr

3.(b) Social Security Number 224-07-0181

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Nona Wilkerson
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) June 26, 1885

8. AGE: Years	Months	Days	If less than one day
59	6	6	...hrs. ...min.

9. Birthplace Sanford, Accomac, Va (Town, county, and state)
10. Usual occupation Barber
11. Industry or business
FATHER 12. Name Samuel Wilkerson
13. Birthplace Va
MOTHER 14. Maiden name Harriett Linton
15. Birthplace Va
16. Informant Mrs. Nona Wilkerson
Address Pocomoke City, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4, 1945 (month) (day) (year)
Cemetery or crematory Federman Cemetary
Location Sanford, Va
18. Funeral director Margarette H. Linton
Address Pocomoke City, Md.
19. Jan. 4, 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 1945 at 11 45 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on Dec 31st 1944.

Immediate cause of death	DURATION
Uremia	3 days
Due to Carcinoma Prostate	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results None made
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE W. E. Gastorney M.D. M. D. or other
Address Pocomoke City Md Date signed 1/3/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15